MDR Tracking Number: M5-04-0114-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 09-08-03.

The IRO reviewed office visits, therapeutic procedures, therapeutic activities, myofasical release, joint mobilization, range of motion measurements, work hardening, and function capacity evaluation rendered from 01-13-03 through 06-02-03 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity for office visits, joint mobilization, myofasical release and therapeutic procedures for 01-13-03 and office visits for 02-24-03, 03-13-03, 05-13-03, and 06-02-03. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

The Medical Review Division has also determined that **the requestor did not prevail** on the issues of medical necessity work hardening, myofasical release, joint mobilization, therapeutic procedures, therapeutic activities, FCE and office visits excluding dates of service listed above. On this basis, the total amount recommended for reimbursement ($315.00) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 11-21-03, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
02-20-03	95851 (3 units)	$108.00	0.00	F	$36.00 per unit	MFG, MGR (II)(C) & (E)	Evaluation submitted supports delivery of service. Recommended Reimbursement $108.00 (3 units $36.00)

03-17-03	97545WH-AP (2 hours)	$128.00		F	$64.00 per hour		Soap notes support delivery of service. Recommended Reimbursement $128.00 ($64.00 for 2 hours)
	97546WH-AP (6 hours)	$384.00		F			Soap notes support delivery of service. Recommended Reimbursement $384.00($64.00 for 6 hours)
03-18-03	97545WH-AP (2 hours)	$128.00		F			Soap notes support delivery of service. Recommended Reimbursement $128.00($64.00 for 2 hours)
	97546WH-AP (6 hours)	$384.00		F		MFG, MGR (II)(C) & (E),	Soap notes support delivery of service. Recommended Reimbursement $384.00($64.00 for 6 hours)
03-19-03	97545WH-AP (2 hours)	$128.00		F			Soap notes support delivery of service. Recommended Reimbursement $128.00($64.00 for 2 hours)
	97546WH-AP (6 hours)	$384.00		F			Soap notes support delivery of service. Recommended Reimbursement $384.00($64.00 for 6 hours)
03-20-03	97545WH-AP (2 hours)	$128.00		F			Soap notes support delivery of service. Recommended Reimbursement $128.00($64.00 for 2 hours)
	97546WH-AP (6 hours)	$384.00		F			Soap notes support delivery of service. Recommended Reimbursement $384.00($64.00 for 6 hours)
TOTAL		$2156.00					The requestor is entitled to reimbursement of **$2156.00**

This Decision is hereby issued this 4th day of May 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 01-13-03, 02-20-03, 02-24-03, 03-07-03, 05-13-03, 03-17-03 through 03-20-03, and 06-02-03 in this dispute.

This Order is hereby issued this 4th day of May 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

Date: April 26, 2004

MDR Tracking #: M5-04-0114-01 **Amended Decision**
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractor physician reviewer who has ADL certification. The Chiropractic physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History
The claimant allegedly injured her left knee, left upper back, and neck region per records describing the said incident dated ___. The claimant was apparently seen for immediate care at ___where she was examined and released, then sought care with ___ on or before 11/19/02. ___ reportedly administered

conservative chiropractic care with manipulations and performed x-rays. Apparently a cervical MRI was ordered, however, results were not available for this review.

The claimant continued to be treated with conservative care, despite no decrease in reported pain levels. A referral for electrodiagnostic study is noted, however, no report was available for review.

The claimant enters a work hardening program on 03/17/03, based on functional capacity exam findings. This apparently proceeded for eight weeks with no improvement in demand levels reported.

A designated doctor examination was performed on 05/20/03 by ___ who found the claimant to be at clinical maximum medical improvement on that date with an impairment rating of 5% whole person.

Treatment continued after the clinical maximum medical improvement date and per last treatment note, apparently a pain management program is being considered.

Requested Service(s)
Office visits and procedures, inclusive of myofascial release, joint mobilization, therapeutic procedures, therapeutic activities, work hardening, and functional capacity evaluation reasonable and medically necessary between 01/13/03 and 06/02/03.

Decision
I disagree with the insurance carrier and find that treatment on 1/13/03 was medically necessary (99213,97265, 97250, and 97112). Office visits on 2/24/03,3/13/03,5/13/03 and 6/2/03 are considered to be medically necessary to follow the claimant.

I agree with the insurance carrier and find that treatment and procedures, including work hardening starting at beyond 2/20/03 were not medically necessary, including myofascial release, joint mobilization, and an FCE. All office visits, with the exception of those dated above, are not medically necessary.

Rationale/Basis for Decision
Established chiropractic guidelines support that an 8-week trial of services is appropriate. In most cases, failure to demonstrate significant improvement after 8 weeks usually is a reasonable stopping point. In this case, it would appear that chiropractic services started on or before 11/19/02. At the time of the first date of service at issue, 1/13/03, the claimant was still within an initial 8-week course of treatment. Provided documentation shows that services on 2/18/03 and 2/19/03 were reimbursed. Whether there were additional services provided between 1/13/03 and 2/20/03, the second date of service at issue, is unknown. By 2/20/03, the claimant had had the benefit of 12 seeks of chiropractic care.

Review of the extensive documentation failed to show any objective benefits from the chiropractic care to date. Complaints were highly subjective. In the absence of objective improvement, continuation of chiropractic services from 2/20/03 and onward is not considered to be medically necessary. Since the chiropractic appears to be the treating doctor, monthly office visits to follow the claimant's progress are considered to be medically necessary, as authorized above.

On 3/17/03, the claimant was started in a WHP. There is no documentation in concurrent SOAP notes, from the chiropractor, that the claimant is suffering from any psychosocial problems (e.g. depression, increased anxiety, etc.) that would impede the rehabilitation process. The claimant had failed to improve significantly from, at this time, 16 weeks of chiropractic and physical medicine modalities. Her VAS score, prior to the FCE was 8/10, and there were documented muscles spasms in the posterior neck, thoracic spine, and lumbar spine. The primary reason for getting an FCE is that there is some evidence that the claimant has progressed and is about ready to return to the workforce. It is unclear, from the

documentation, as to what medications the claimant was taking, that might have helped to ameliroate the symptomatology. If she wasn't getting any, she should have been, If she was getting medications, they clearly weren't effective, and there is no documentation, in office notes provided by the chiropractor, from 11/19/02 to 3/14/03, of any other physicians seeing the claimant for medication management. In fact, if one feads the subjective and objective notes from this myriad of office visits, they are, not just similar, but nearly verbatim. Pain in the posterior neck is 8/10, lumbar spine is 8/10, thoracic spine is 8/10 and left knee 6/10. The documentation is substandard and the value of such notes questionable. What is clear is that a failure to progress in the least with VAS score improvement does not support that a WHP will be successful, making it not medically necessary. (And, in fact, there was no improvement in PDL classification secondary to the WHP.) The documentation, therefore, does not support the medical necessity for a WHP.

In accordance with commission rule 102.4(h), I hereby verify that a copy of this Independent Review Organizaiton (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 26th day of April 2003.